Request to Inspect or Copy Protected Health Information

Date:_____
Name:_____

I. Request to Inspect or Copy Protected Health Information

I hereby request to review protected health information (PHI) about me in a "designated record set" held by the Kentucky Employees Health Plan (the "Plan") in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

The Department of Employee Insurance only maintains demographic protected health information which includes personal identifiers, enrollment, eligibility, family dependents and qualifying event information. The third-party claims administrator (Humana) and third-party pharmacy benefits manager (Express Scripts) maintain medical condition and treatment protected health information. The third-party administrator will have a separate Form.

Check any of the below, as applicable:

____ I want to inspect PHI about myself maintained in the designated record set.
____ I want to obtain a copy of PHI about myself that is maintained in the designated record set.
____ I request that a copy of PHI about myself be mailed to the following address:

_____
_____

____ I request that the information be provided in the following format: (circle one)

Paper Computer Disk CD ROM E-Mail

I understand that if the format requested is not readily producible, the Plan will provide a readable hard copy form or such other form or format as agreed to by the Plan and by me.
I do/do not (circle one) agree that the Plan may provide a summary of the health information instead of allowing me to review the information.

If the same PHI that is the subject of a request for access is maintained in more than one designated record set or at more than one location, the Plan will only produce the PHI once in response to a request.

II. Other Important Information

I understand that the Plan has 30 days to respond to this request, and that if someone else holds the information or the information is off-site, the response time is 60 days. If the Plan is unable to take action within the applicable time period, the Plan may extend the time for such action by 30 days, provided that the Plan, within the applicable time period, gives me a written statement of the reasons for the delay and the date by which the Plan will complete its action on the request.

I understand that if the Plan grants this request, in whole or in part, it will inform me of the acceptance of this request and provide the access requested. In that event, the Plan will arrange with me for a convenient time and place to inspect or copy the PHI, or it will provide me with a copy as I have requested. However, if the Plan denies the request, in whole or in part, it will provide me with a written denial. I agree to pay any fees for copying, summarizing, or explaining my health information. Fees will be reasonable and cost-based and will include only the cost of copying, postage (if I request that a copy or summary be mailed), and preparation of a summary (if I agree to a summary).

I understand that this request does not apply to certain health information, including (1) information that is not held in the designated record set; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; and (4) other health information not subject to the right to access information under HIPAA.

III. Signature of Member or Member's Representative

_____ _____

Signature of member or member's representative **Date**

(Form MUST be completed before signing.)

Printed name of the member's personal representative:

_____

Relationship to the member, including authority for status as representative:

_____

_____

Signature

_____

Printed

Department of Employee Insurance
501 High Street, 2nd Floor
Frankfort, Kentucky 40601
(502) 564-6534